NH Medical Control Board

Richard M. Flynn Fire Academy
222 Sheep Davis road
Concord, NH

APPROVED MINTUES

March 17, 2005

Members Present: Donavon Albertson, MD; Patrick Lanzetta, MD; Joseph Mastromarino, MD; Frank Hubbell, DO; Jim Martin, MD; Douglas McVicar, MD; Joseph Sabato, MD; William Siegart, DO; John Sutton, MD; Tom D'Aprix, MD; Sue Prentiss, Bureau Chief.

Members Absent: Jeff Johnson, MD; Chris Fore, MD; Norman Yanofsky, MD.

Guests: Jeffrey Stone, Janet Houston, Fred Heinrich, Dave Dubey, Doug Martin.

Bureau Staff: Vicki Blanchard, Kathy Doolan, Eric Perry, Clay Odell, Liza Burrill.

I. CALL TO ORDER

Item 1. The meeting of the NH Medical Control Board was called to order by McVicar on March 17, 2005 at 09:00.

Item 2. McVicar introduced Paramedic Vicki Blanchard who has taken over from John Clark as NH Bureau of EMS ALS Coordinator.

II. ACCEPTANCE OF MINUTES

Item 1. **CORRECTIONS**
The following corrections to the minutes of January 20, 2005 were made:

- Change "Hubbard" to "Hubbell" throughout the document.
- Jeff Stone noted that at the time of Chris DeWolfe's death he was employed by Newington Fire and had previously been employed at Dover Fire.

Siegart moved, "to accept the minutes as corrected." Hubbell 2nd.
Vote: Unanimously approved.

III. DISCUSSION AND ACTION PROJECTS

Item 1: PROTOCOLS – Corrections and follow-ups

McVicar announced the 2005 NH Patient Care Protocols have been posted on the NH BEMS website [http://www.state.nh.us/safety/ems/protocol.html]. Our new ALS Coordinator, Vicki Blanchard, has already begun rollout presentations to various hospitals and will continue throughout the next couple of months.

Now that the rollout process has begun, previously unnoticed errors, omissions and comments have been brought to attention. Fortunately, almost all of these involve clarification of wording, and do not involve major substantive changes. Discussion and changes of these errors, omissions and comments are as follows:

1. Meperidine: At the request of several providers the Medical Control Board reconsidered its decision to eliminate meperidine (Demerol) from the approved medication list. After reconsideration, the MCB decided not to reintroduce meperidine. Reasons were as follows:

- Siegart: fentanyl is more stable and more fitting for prehospital use, as it is short acting and has little effect on the blood pressure.
- Albertson: adverse drug reactions to opiates usually present as side effects, rather than true anaphylaxis. There is no need to have three separate agents to deal with the rare true med allergies, two should cover the needs of almost all patients.
- McVicar: because it is fast acting, and short-acting fentanyl has special advantages in the EMS setting.
- Lanzetta: echoed Albertson's comments.
- Lanzetta: more education on fentanyl needed if EMS is to actually take advantage of its theoretical benefits. Leave Demerol out of the protocols.
- Hubbell: Demerol is an old and dirty drug with more complications and its use nationwide is decreasing.
- Siegart: Agreed with Lanzetta that education at the rollouts was important.
- McVicar: The MCB cannot make this decision unilaterally. If we decide to place meperidine back on the approved drug list, we will need the concurrence of the NH Board of Pharmacy.

McVicar called for a vote. It was the unanimous sense of the group that the protocol not be changed. Therefore morphine and fentanyl -- but not meperidine -- are approved for EMS use. The board urges emphasis on analgesic education."
Vote: Unanimously passed.

2. Promethazine: Hubbell moved that, "wording regarding promethazine in children under two year of age be changed to reflect the FDA black box warning verbatim." D'Aprix 2nd.
Vote: Unanimously passed.

The FDA wording is as follows: "Phenergan is contraindicated for use in pediatric patients less than two years of age because of the potential for fatal respiratory depression."

3. Adenosine: Albertson moved that on page 45 under the Tachycardia protocol, "adenosine dose be changed from 6 - 12 mg to 6 mg rapid IVP with repeat dose X 2 of 12 mg " Hubbell 2nd.
Vote: Unanimously passed.

4. PEA to ASYSOLE: J. Martin moved that on page 49 under the Paramedic Standing Orders for the Cardiac Arrest protocol, "The word 'PEA' be changed to 'ASYSTOLE'." Albertson 2nd.
Vote: Unanimously passed

5. Intermediate PEA: J. Martin moved that on page 49 under the Intermediate Standing Orders for the Cardiac Arrest protocol, administration of atropine for PEA be changed to "If Bradycardic, Atropine 1mg…" Albertson 2nd.
Vote: Unanimously passed.

6. Bradycardia and Atropine: Albertson moved that on page 43 under the Bradycardia protocol "change the IVP dose of atropine from 1mg to 0.5 mg - 1.0 mg and the ETT dose from 2mg to 1mg - 2mg, to reflect ACLS standards." Lanzetta 2nd.
Vote: Unanimously passed.

7. Nitroglycerin Paste and Acute Coronary Syndrome (ACS): This topic brought about much discussion regarding the use of nitroglycerin paste versus IV nitroglycerin. Arguments raised were:

- Concerns with the inability to titrate nitroglycerine paste,
- General consensus that IV nitroglycerin is preferable,
- Although we have no specific data, many feel that IV pumps – which are required for use of IV nitroglycerin – are not widely available on ambulances.
- Comparative indications, advantages and disadvantages of repeat dosing with sublingual nitroglycerin.
- Paramedic diagnosis of AMI versus ACS.

After much discussion McVicar called for a vote to change the protocol to read, "if IV nitroglycerin is unavailable, then nitroglycerin paste 1" – 2" transdermally may be used."
Vote: 6 Yes, 3 No, 1 Abstaining. Protocol is changed.

8. Phenylephrine in post-resuscitation hypotension in the Cardiac Arrest Protocol 3.4, on page 49: The statement of dosing is changed to "40 - 180 mcg/min infusion", consistent with other medications on the list.

McVicar asked for a vote to change as above.
Vote: Unanimously passed.

9. Activated Charcoal: Since the March 1, 2005 release of the protocol, many questioned why activated charcoal was removed from the approved medication list. Much discussion ensued regarding this topic.

Arguments against the drug were:

- Risk of aspiration.
- Poison Control Center employees no longer 100% certified.
- Messy to administer in an ambulance.

Arguments for the drug were:

- It is in the EMT-Basic curriculum.
- Risk of aspiration small. Basics are taught not to administer to patients with decreased LOC.
- Beneficial especially if long transport times.
- Poison Control and Medical Control available for direction of administration.
- Generally considered harmless.
- Still an accepted "Standard of Care."

McVicar moved the question, "under the Basic Standing Orders of protocols 2.11 and 2.11P (Poisoning/ Substance Abuse/Overdose - Adult/Pediatric) consider activated charcoal 25 - 50 gm PO."
Vote: 7 Yes, 1 No, 2 Abstaining, motion passed.

10. Epinephrine 1:1000 for Asthma/COPD/RAD - Pediatric: J Martin moved to correct a typo on page 25 under the Paramedic Standing Orders for Pediatric Asthma/COPD/RAD protocol, Martin moved to add the dose 0.01mg/kg to the epinephrine consideration to read, "Consider epinephrine (1:1,000) 0.01 mg/kg (0.01ml/kg) SQ…" Albertson 2nd.
Vote: Unanimously passed.

11. Flumazenil and diphenhydramine: J Martin questioned the wording for flumazenil and diphenhydramine under the Behavioral Emergencies Including Suicide Attempts and Threats protocol on page 27. The present wording is confusing. Flumazenil and diphenhydramine are intended to be available to treat iatrogenic overdosing of benzodiazepines or haloperidol. The present wording seems to imply that they may be used directly for treatment of a behavioral emergency.

This led to further discussion of the Poisoning/Substance Abuse/Overdose Protocols 2.11 & 2.11P (pages 38 & 39). Some members felt that flumazenil is

not safe enough to use for overdoses of unknown substances, and should only used if the diagnosis of benzodiazepine overdose is known.

D'Aprix moved that "1) flumazenil be removed from the Poisoning/Substance Abuse/Overdose Protocols 2.11 & 2.11P, and 2) under the Behavioral Emergencies Including Suicide Attempts and Threats - Protocol 2.2 add …'Flumazenil 0.2 mg IV over 30 seconds to reverse the effects of benzodiazepines' and 'Diphenhydramine 50 mg IV/IM for acute dystonic reaction to Haloperidol'. " Martin 2nd.
Vote: Unanimously passed.

12. STOP: Sue Prentiss informed the MCB that the "STOP" pink card, on page 81 under the Do Not Resuscitate (DNR) Orders - Protocol 6.4, is now referred to as the "PORT" (Physician Order Regarding Treatment) pink card.

McVicar called for a vote "to change "STOP" to "PORT" on page 81."
Vote: Unanimously passed.

13. Grammatical correction: McVicar asked that ALS Coordinator Blanchard change the wording on pages 93 & 106 to add the word "is" and "medication" as follows:…"medication is ordered…" and "…continue that medication during transfer…"

14. Benzodiazepines for spasms in femur fractures, dislocated shoulders and back spasm: At the Speare Hospital protocol rollout on 15 March, ALS providers urged that diazepam be included under the pain management protocol for treatment of muscle spasms associated, for example, with femur fractures, dislocated shoulders and back spasms.

This request was denied for the following reasons:

- Lanzetta: Diazepam does not actually stop the spasms, but sedates the patient.
- Sutton: Not very effective, unless in large dose, then cardiac concerns.
- Hubbell: If femur fraction is properly tractioned, spasms should be minimized. If spasm were that bad in spite of adequate traction, too large a dose of diazepam would be required.
- Hubbell: Not enough diazepam to relieve back spasm for patients on a long board, and again increased doses could have increased cardiac risks.

15. Needle and Surgical Cricothyrotomy: Sutton expressed concern with the inconsistency in the needle direction specified for access in the Needle Cricothyrotomy and Surgical Cricothyrotomy procedures on pages 64 & 65 of the Advanced Airway Management Protocol/Failed Airway Options - Protocol 5.0.

Sutton suggested that the pilot needle procedure under Surgical Cricothyrotomy be removed, stating that if a paramedic cannot find the anatomical landmarks of the cricothyroid membrane, they should not be doing the procedure. He stated he felt this protocol was one to be considered for prerequisites.

Sutton suggested the Surgical Cricothyrotomy protocol be changed as follows:

- "…Locate the cricothyroid membrane utilizing correct anatomical landmarks.
- Prep the area with an antiseptic swab (Betadine).
- Make a 1-inch vertical incision through the skin and subcutaneous tissue using a scalpel.
- Using blunt dissection technique, expose the cricothyroid membrane.
- Make a horizontal stabbing incision approximately 1/2 inch through the membrane.
- Using a dilator, hemostat, or gloved finger to maintain surgical opening, insert the cuffed tube into the trachea…"

Additionally, Sutton suggested changing the insertion of the needle for the needle cricothyrotomy to read "…insert the needle through the cricothyroid membrane perpendicular to the surface of the membrane…"

The Board agreed unanimously to Sutton's suggestions, and directed ALS Coordinator Blanchard to draft a copy of the changes and forward via email to Sutton for review.

16. Traumatic Brain Injury: Sutton expressed additional concern with the Traumatic Brain Injury - Protocol 4.4. Sutton's concerns were with the signs and symptoms of cerebral herniation and hyperventilation.

After discussion, the board decided that since the protocols were based on recommendations of a national expert body, we would keep them intact at this time. But recognizing the concern of Sutton and others that standards of care of Traumatic Brain Injury are rapidly evolving, the Board will continue to monitor the state of the art.

17. Advanced Airway Management Protocol/Failed Airway Options - Protocol 5.0: Janet Houston pointed out the inconsistencies in the definition of a child:

- Routine Patient Care - Protocol 1.0, the medical definition of a pediatric is …"a child who fits on the Broselow tape…"
- Advanced Airway Management Protocol/Failed Airway Options - Protocol 5.0, Nasotracheal Intubation Procedure: "…Patient must be 12 years of age or older."

- ❑ Advanced Airway Management Protocol/Failed Airway Options - Protocol 5.0, Surgical Cricothyrotomy: "…in a patient > 8 years old."
- ❑ Advanced Airway Management Protocol/Failed Airway Options - Protocol 5.0, Combitube Procedure: "…Patient must be > 50 kg."

Hubbell moved "to change Nasotracheal intubation and surgical cricothyrotomy to a person greater the then length of a Broselow tape." Lanzetta 2nd.
Vote: Unanimously passed.

Hubbell moved, "to recommend to the Bureau of EMS to add the Broselow tape to the State's required equipment list." Lanzetta 2nd.
Vote: Unanimously passed.

The Board further directed ALS Coordinator Blanchard to change the wording "Broselow tape" to "Pediatric length based resuscitation tape (Broselow)", throughout document.

Additionally, Blanchard was directed to obtain the manufacturer's recommendations for Combitube sizing, by height, weight or age.

18. Reglan correction: J Martin moved that under the Approved Medication List on page 105, the trade name for metoclopramide which is shown as "Zofran" be corrected to "Reglan". D'Aprix 2nd.
Vote: Unanimously passed.

Item 2: BLIND INSERTION AIRWAY
Doug Martin, NREMT-P, Frisbee Hospital, passed out information about the "King LT, Supraglottic Reusable & Disposable Airway." In the consideration of limited time, the Board was asked to review the information and be prepared for discussion at the May 2005 meeting.

Item 3: PROTOCOL FORMAT
Blanchard informed the Board that she was working with Graphic Services for a quote on a flip book for the protocols. She is also working on formatting the protocols for PDA's and PPC 's. More information will be brought forward at the May 2005 meeting.

Item 4: PROTOCOL PREREQUISITES
Albertson briefly presented the idea of putting a prerequisite statement on all the protocols. This statement might be a simple statement of qualification for many simple protocols such as BLS CPR or much more specific and more defined in cases such as RSI. In the interest of time, further discussion on this item was tabled until May 2005.

Item 5: NEW PROTOCOL CYCLE - LOGISTICAL PLANNING
Blanchard reported that we are now in "Year 1" of the two-year cycle for the creation of the 2007 Protocols. A brief discussion was held of the whether deadlines should be established more flexibly. This will be further discussed at the May 2005 meeting.

Item 6: NEW PROTOCOL CYCLE - STATE-OF-THE-ART OF EMS PLANNING:
During Year 1 of the protocols cycle we need to examine and discuss the future of prehospital emergency medicine worldwide and how NH should proceed. Further intermediate and long range planning will be a discussion topic at the May 2005 meeting.

IV. INCUBATING PROJECTS & SUBCOMMITEE REPORTS

Item 1: ACEP REPORT
No report.

Item 2: Board of Pharmacy Liaison
No report.

Item 3: Intersection Initiative
Sabato reported that HB145 called for a Medical Control Board for guidance referencing driving issues as well as to serve as liaison for the Department of Safety and Health Care Community. Sabato further reported that NH was one of sixteen states without medical guidance on health-related driving issues.

Sabato reported there would be a NH Public Health Fall Conference. Items addressed would include: AED, Stroke Centers and Injury Prevention. More information will be available at a later date.

Sabato reported that the Injury Prevention report was sent to NHTSA a couple of weeks ago.

Sabato reported: a new yahoo group has been created for "Emergency Public Health," you can go to Yahoo Groups to access.

Item 4: NH BEMS/Division of Fire Standards & Training and EMS Report:
Sue Prentiss, Bureau Chief gave an abbreviated version of the attached Bureau report.

Rick Mason, Director FST & EMS, reported on the following:

HB 257: On March 29, 2005 at 09:00 the House ED&A Committee will be holding a hearing on HB 257. Mason stated this Committee tends to be

against anything that would eliminate items from Administrative Rule, so we will have our work cut out for us making the case for HB257.

SB 88: Licensure for RN's with Interfacility training module. In limbo at this time.

HB 565: This bill needed a couple of paragraph changes to include EMS in the whole loop; with some small changes this will be taken care of.

HB 705 The “Seatbelts for all” bill: Mason urged all to contact their local representatives as he forecasts a floor fight on this issue in the House.

Minutes: Mason advised that per the NH Right to Know Law, the minutes of our meetings are to be available to the public with 144 hours of the close of the meeting. In order to help achieve this goal, he has provided a new recording system. He stated that when motions are made if people could actually state their name, give the motion, and whoever seconds the motion state their name, it will really enhance things for the people taking the minutes.

Chairmen's Breakfast with Commissioner: Mason advised that he would like to set up a “Chairmen's Breakfast” for the chairmen of the MCB, EMS Coordinating Board, Trauma Medical Review Committee and Fire Standards & Training Commission to meet with the Commissioner of Safety. McVicar suggested that the Chairmen get together at the break and chose a possible date for this meeting.

Item 5: NH E-911 Report:

No report.

Item 6: NH Trauma System:

Sutton reported that the Trauma System continues to work on the re-verification process. Littleton and Southern New Hampshire Medical Center have been approved for re-verification.

North Country Transfer Conference: Great attendance, with good exchange of early ideas as well as areas that need further investigation. Considered a "good start." A subcommittee was formed and will continue to move forward with ideas and items from the conference. Additionally, all looked forward to another conference in 2006.

Sutton added that the Trauma Committee was looking at modifying the Level II scheme specifically for neurosurgery and orthopedics, to allow continued participation. The modification would require 4 or 5 points to be changed so if subspecialties were not available the hospital could still participate.

Item 7: TEMSIS

No report. McVicar asked that a TEMSIS update become a regular part of each MCB agenda. Fred Von Recklinghausen, NREMT-P, NH BEMS Research Coordinator plans to work more closely with the board.

Item 8: Items of Interest/Public Comment:

Albertson stated that the *NY Times* reported yesterday that Homeland Security had developed 15 National Planning Scenarios for terror attack on the US, plus a list of as many as 1500 local tasks might that be needed to respond to these attacks. Albertson requested that Blanchard research more information regarding the article and the scenarios, and circulate a copy of the article to members.

Sabato stated that a recent report from Homeland Security shows that of all funds released, only 4% had gone to EMS training.

V. NEXT MEETING

Ordinarily the May, July and September meetings are hosted by various hospitals around the state. At this time we have not received any invitations for this year's meetings on the road. Blanchard and Kathy Doolan will plan the next meeting place and let all know.

VI. ADJOURNMENT

Sabato moved, "to adjourn the meeting." Sutton 2nd.
Vote: Unanimously passed. Time: 12:00

Respectfully Submitted,

Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard, ALS Coordinator)